



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

METHODIST HEALTH SYSTEM
4040 N CENTRAL EXPRESSWAY SUITE 600
DALLAS TX 75204

Respondent Name

INDEMNITY INSURANCE CO OF NORTH
AMERICA

Carrier's Austin Representative Box

Box Number 15

MFDR Tracking Number

M4-12-2164-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "DRG code is correct"

Amount in Dispute: \$15,804.95

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We have escalated the bill for additional *payment and review of the bill has been completed. Clinical Validation has review and confirmed zero allowance is appropriate. DRG was denied: DRG 623 is for wound debridement and skin graft – Multiple I&Ds were done, however no documentation was found that substantiates a skin graft.*"

Response Submitted by: Gallagher Bassett Services, Inc., 6504 International Parkway, Plano, TX 75093

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 25, 2010 to April 16, 2010	Inpatient Hospital Surgical Services	\$15,804.95	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.

2. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated August 16, 2010

- 16 – (16) CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. ADDITIONAL INFORMATION IS SUPPLIED USING REMITTANCE ADVICE REMARKS CO

Explanation of benefits dated October 18, 2010

- 19 – (19) PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT.

Explanation of benefits dated October 18, 2010

- 19 – (19) PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT.
- BL – (BL) THIS BILL IS A RECONSIDERATION OF A PREVIOUSLY REVIEWED BILL, ALLOWANCE AMOUNTS DO NOT REFLECT PREVIOUS PAYMENTS.
- BL – (BL) ADDITIONAL ALLOWANCE IS NOT RECOMMENDED AS THIS CLAIM WAS PAID IN ACCORDANCE WITH STATE GUIDELINES, USUAL/CUSTOMARY POLICIES, OR THE
- 19 – (197) THIS LINE WAS INCLUDED IN THE RECONSIDERATION OF THIS PREVIOUSLY REVIEWED BILL.

Explanation of benefits dated November 15, 2010

- 16 – (16) CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. ADDITIONAL INFORMATION IS SUPPLIED USING REMITTANCE ADVICE REMARKS CO

Explanation of benefits undated

- 18 – (18) DUPLICATE CLAIM/SERVICE.
- BL – (BL) DATE (S) OF SERVICE EXCEED (95) DAY TIME PERIOD FOR SUBMISSION PER RULE 408.027 AND BULLETIN NO. B-0037-05A.
- BL – (BL) DATE (S) OF SERVICE EXCEED 11 MONTH TIME PERIOD FOR SUBMISSION PER RULE 134.801C

Explanation of benefits undated

- 18 – (18) DUPLICATE CLAIM/SERVICE.

Explanation of benefits undated

- 18 – (18) DUPLICATE CLAIM/SERVICE.

Issue

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

28 Texas Administrative Code §133.307(c)(1) and (c)(1)(A) states: "Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. ... A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The dates of the service in dispute are March 25, 2010 through April 16, 2010. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on February 23, 2012. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307, subparagraph (B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute. For that reason, the merits of the issues raised by both parties to this dispute have not been addressed.

Authorized Signature

_____ Signature	_____ Medical Fee Dispute Resolution Officer	_____ May 24, 2012 Date
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YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.